

Adopted	Rejected
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COMMITTEE REPORT

YES:	11
NO:	0

MR. SPEAKER:

*Your Committee on Public Health, to which was referred House Bill 1591, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill **be amended** as follows:*

- 1 Delete the title and insert the following:
- 2 A BILL FOR AN ACT to amend the Indiana Code concerning
- 3 human services.
- 4 Delete everything after the enacting clause and insert the following:
- 5 SECTION 1. IC 2-5-36 IS ADDED TO THE INDIANA CODE AS
- 6 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON
- 7 PASSAGE]:
- 8 **Chapter 36. Indiana Affordable Care Study Committee**
- 9 **Sec. 1. As used in this chapter, "Affordable Care Act" refers to**
- 10 **the federal Patient Protection and Affordable Care Act (P.L.**
- 11 **111-148), as amended by the federal Health Care and Education**
- 12 **Reconciliation Act of 2010 (P.L. 111-152).**
- 13 **Sec. 2. As used in this chapter, "committee" refers to the**
- 14 **Indiana affordable care study committee established by section 4**
- 15 **of this chapter.**

1 **Sec. 3.** As used in this chapter, "exchange" refers to an
2 American health benefit exchange established for Indiana under
3 the Affordable Care Act.

4 **Sec. 4. (a)** There is established the Indiana affordable care study
5 committee.

6 **(b)** The committee shall study and make recommendations
7 concerning the following:

8 **(1)** The implementation of an exchange established for
9 Indiana.

10 **(2)** The definition of "essential health benefits" for use in
11 Indiana under the Affordable Care Act, including ensuring
12 that the definition results in adequate benefits.

13 **(c)** The committee shall receive and consider annual reports
14 from the office of the secretary of family and social services
15 concerning the status and operation of the exchange established for
16 Indiana.

17 **(d)** The committee shall, not later than November 1 of each
18 year, report the committee's findings and recommendations
19 concerning the committee's study under subsection (b) to the
20 legislative council in an electronic format under IC 5-14-6.

21 **Sec. 5.** The committee shall operate under the policies governing
22 study committees adopted by the legislative council.

23 **Sec. 6. (a)** The committee consists of the following voting
24 members:

25 **(1)** Four (4) members of the senate, not more than two (2) of
26 whom may be members of the same political party, appointed
27 by the president pro tempore.

28 **(2)** Four (4) members of the house of representatives, not
29 more than two (2) of whom may be members of the same
30 political party, appointed by the speaker.

31 **(3)** The secretary of family and social services or the
32 secretary's designee.

33 **(4)** The commissioner of the state department of health or the
34 commissioner's designee.

35 **(5)** The commissioner of insurance or the commissioner's
36 designee.

37 **(6)** One (1) member representing the insurance industry.

38 **(7)** One (1) member representing hospitals.

1 **(8) One (1) member representing physicians.**

2 **(b) The president pro tempore shall appoint a chairperson of the**
3 **committee during each even-numbered year. The speaker shall**
4 **appoint a chairperson of the committee during each odd-numbered**
5 **year.**

6 **Sec. 7. The affirmative votes of a majority of the voting**
7 **members appointed to the committee are required for the**
8 **committee to take action on any measure, including final reports.**

9 **Sec. 8. This chapter expires July 1, 2016.**

10 SECTION 2. IC 12-15-2-3.5 IS ADDED TO THE INDIANA CODE
11 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
12 1, 2013]: **Sec. 3.5. An individual:**

13 **(1) who is:**

14 **(A) at least sixty-five (65) years of age; or**

15 **(B) disabled, as determined by the Supplemental Security**
16 **Income program; and**

17 **(2) whose income and resources do not exceed those levels**
18 **established by the Supplemental Security Income program;**
19 **is eligible to receive Medicaid assistance if the individual's family**
20 **income does not exceed one hundred percent (100%) of the federal**
21 **income poverty level for the same size family.**

22 SECTION 3. IC 12-15-2-17, AS AMENDED BY P.L.196-2011,
23 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
24 JULY 1, 2013]: **Sec. 17. (a) Beginning January 1, 2014, the office**
25 **may apply this section only to the following Medicaid applicants or**
26 **Medicaid recipients:**

27 **(1) An individual whose eligibility for Medicaid does not**
28 **require a determination of income by the office, including an**
29 **individual receiving Supplemental Security Income.**

30 **(2) An individual who is at least sixty-five (65) years of age if**
31 **age is a condition of eligibility.**

32 **(3) An individual whose eligibility is being determined on the**
33 **basis of being blind or disabled, or on the basis of being**
34 **treated as blind or disabled.**

35 **(4) An individual who requests coverage for long term care**
36 **services and supports for the purpose of being evaluated for**
37 **an eligibility group under which long term care services or**
38 **supports are covered, including the following:**

- 1 **(A) Nursing facility services.**
 2 **(B) Nursing facility level of care services provided in an**
 3 **institution.**
 4 **(C) Intermediate care facility services for the mentally**
 5 **retarded.**
 6 **(D) Home and community based services.**
 7 **(E) Home health services.**
 8 **(F) Personal care services.**
 9 **(5) An individual applying for Medicare cost sharing**
 10 **assistance.**
 11 ~~(a)~~ **(b)** Except as provided in subsections ~~(b)~~ **(c)** and ~~(d)~~ **(e)**, if an
 12 applicant for or a recipient of Medicaid:
 13 (1) establishes one (1) irrevocable trust that has a value of not
 14 more than ten thousand dollars (\$10,000), exclusive of interest,
 15 and is established for the sole purpose of providing money for the
 16 burial of the applicant or recipient;
 17 (2) enters into an irrevocable prepaid funeral agreement having a
 18 value of not more than ten thousand dollars (\$10,000); or
 19 (3) owns a life insurance policy with a face value of not more than
 20 ten thousand dollars (\$10,000) and with respect to which
 21 provision is made to pay not more than ten thousand dollars
 22 (\$10,000) toward the applicant's or recipient's funeral expenses;
 23 the value of the trust, prepaid funeral agreement, or life insurance
 24 policy may not be considered as a resource in determining the
 25 applicant's or recipient's eligibility for Medicaid.
 26 ~~(b)~~ **(c)** Subject to subsection ~~(d)~~ **(e)**, if an applicant for or a
 27 recipient of Medicaid establishes an irrevocable trust or escrow under
 28 IC 30-2-13, the entire value of the trust or escrow may not be
 29 considered as a resource in determining the applicant's or recipient's
 30 eligibility for Medicaid.
 31 ~~(c)~~ **(d)** Except as provided in IC 12-15-3-7, if an applicant for or a
 32 recipient of Medicaid owns resources described in subsection ~~(a)~~ **(b)**
 33 and the total value of those resources is more than ten thousand dollars
 34 (\$10,000), the value of those resources that is more than ten thousand
 35 dollars (\$10,000) may be considered as a resource in determining the
 36 applicant's or recipient's eligibility for Medicaid.
 37 ~~(d)~~ **(e)** In order for a trust, an escrow, a life insurance policy, or a
 38 prepaid funeral agreement to be exempt as a resource in determining

1 an applicant's or a recipient's eligibility for Medicaid under this section,
 2 the applicant or recipient must designate the office or the applicant's or
 3 recipient's estate to receive any remaining amounts after delivery of all
 4 services and merchandise under the contract as reimbursement for
 5 Medicaid assistance provided to the applicant or recipient after
 6 fifty-five (55) years of age. The office may receive funds under this
 7 subsection only to the extent permitted by 42 U.S.C. 1396p. The
 8 computation of remaining amounts shall be made as of the date of
 9 delivery of services and merchandise under the contract and must be
 10 the excess, if any, derived from:

- 11 (1) growth in principal;
- 12 (2) accumulation and reinvestment of dividends;
- 13 (3) accumulation and reinvestment of interest; and
- 14 (4) accumulation and reinvestment of distributions;

15 on the applicant's or recipient's trust, escrow, life insurance policy, or
 16 prepaid funeral agreement over and above the seller's current retail
 17 price of all services, merchandise, and cash advance items set forth in
 18 the applicant's or recipient's contract.

19 SECTION 4. IC 12-15-3-1, AS AMENDED BY P.L.196-2011,
 20 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 21 JULY 1, 2013]: Sec. 1. (a) Except as provided in subsections (b) and
 22 (c) and section 7 of this chapter, an applicant for or recipient of
 23 Medicaid is ineligible for assistance if the total cash value of money,
 24 stock, bonds, and life insurance owned by:

- 25 (1) the applicant or recipient is more than one thousand five
 26 hundred dollars (\$1,500) for assistance to the aged, blind, or
 27 disabled; or
- 28 (2) the applicant or recipient and the applicant's or recipient's
 29 spouse is more than two thousand two hundred fifty dollars
 30 (\$2,250) for medical assistance to the aged, blind, or disabled.

31 (b) In the case of an applicant who is an eligible individual, a
 32 Holocaust victim's settlement payment received by the applicant or the
 33 applicant's spouse may not be considered when calculating the total
 34 cash value of money, stock, bonds, and life insurance owned by the
 35 applicant or the applicant's spouse.

36 (c) In the case of an individual who:

- 37 (1) resides in a nursing facility or another medical institution; and
- 38 (2) has a spouse who does not reside in a nursing facility or

1 another medical institution;
 2 the total cash value of money, stock, bonds, and life insurance that may
 3 be owned by the couple to be eligible for the program is determined
 4 under IC 12-15-2-24.

5 **(d) This section expires December 31, 2013.**

6 SECTION 5. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE
 7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 8 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall
 9 determine eligibility for a Medicaid applicant or Medicaid
 10 recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**

11 **(b) If an individual:**

12 **(1) resides in a nursing facility or another medical institution;**
 13 **and**

14 **(2) has a spouse who does not reside in a nursing facility or
 15 another medical institution;**

16 **the total cash value of money, stock, bonds, and life insurance that
 17 may be owned by the couple to be eligible for Medicaid is
 18 determined under IC 12-15-2-24.**

19 SECTION 6. IC 12-15-3-2, AS AMENDED BY P.L.196-2011,
 20 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 21 JULY 1, 2013]: **Sec. 2. (a) Except as provided in section 7 of this
 22 chapter, if the parent of an applicant for or a recipient of assistance to
 23 the blind or disabled who is less than eighteen (18) years of age owns
 24 money, stock, bonds, and life insurance whose total cash value is more
 25 than one thousand five hundred dollars (\$1,500), the amount of the
 26 excess shall be added to the total cash value of money, stock, bonds,
 27 and life insurance owned by the applicant or recipient to determine the
 28 recipient's eligibility for Medicaid under section 1 of this chapter.**

29 **(b) However, a Holocaust victim's settlement payment received by
 30 the parent of an applicant for or a recipient of assistance may not be
 31 added to the total cash value of money, stock, bonds, and life insurance
 32 owned by the applicant or recipient to determine the recipient's
 33 eligibility for Medicaid under section 1 of this chapter.**

34 **(c) This section expires December 31, 2013.**

35 SECTION 7. IC 12-15-3-3, AS AMENDED BY P.L.196-2011,
 36 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 37 JULY 1, 2013]: **Sec. 3. (a) Except as provided in section 7 of this
 38 chapter, if the parents of an applicant for or a recipient of assistance to**

1 the blind or disabled who is less than eighteen (18) years of age own
 2 money, stock, bonds, and life insurance whose total cash value is more
 3 than two thousand two hundred fifty dollars (\$2,250), the amount of the
 4 excess shall be added to the total cash value of money, stock, bonds,
 5 and life insurance owned by the applicant or recipient to determine the
 6 recipient's eligibility for Medicaid under section 1 of this chapter.

7 **(b) This section expires December 31, 2013.**

8 SECTION 8. IC 12-15-12-22.2 IS ADDED TO THE INDIANA
 9 CODE AS A NEW SECTION TO READ AS FOLLOWS
 10 [EFFECTIVE JULY 1, 2013]: **Sec. 22.2. The office shall include in a**
 11 **contract entered into between the office and a managed care**
 12 **organization requirements for managed care organizations to**
 13 **actively implement policies that do the following:**

14 **(1) Increase positive health outcomes.**

15 **(2) Promote personal responsibility and informed decision**
 16 **making by a Medicaid recipient concerning the Medicaid**
 17 **recipient's health.**

18 **(3) Promote the greatest degree of independence and use of**
 19 **community based supports, including home and community**
 20 **based services, for long term care.**

21 **(4) Prevent fraud, waste, and abuse by both Medicaid**
 22 **providers and Medicaid recipients participating in the**
 23 **program.**

24 SECTION 9. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE
 25 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
 26 UPON PASSAGE]: **Sec. 3. (a) Before July 1, 2013, the office shall**
 27 **apply to the United States Department of Health and Human**
 28 **Services to amend the state Medicaid plan or for a Medicaid**
 29 **waiver to require a Medicaid recipient who is eligible for Medicaid**
 30 **based on the individual's aged, blind, or disabled status to enroll in**
 31 **the risk-based managed care program.**

32 **(b) The office may apply to the United States Department of**
 33 **Health and Human Services for authorization to require other**
 34 **Medicaid population groups to enroll in risk-based managed care.**

35 **(c) The office may not implement the state plan amendment or**
 36 **Medicaid waiver described in this section until the office files an**
 37 **affidavit with the governor attesting that the state plan amendment**
 38 **or Medicaid waiver applied for under this section has been**

1 approved by the United States Department of Health and Human
2 Services. The office shall file the affidavit under this subsection not
3 later than five (5) days after the office is notified that the state plan
4 amendment or Medicaid waiver described in this section has been
5 approved.

6 (d) The office shall, not later than October 1, 2013, implement
7 the state plan amendment or Medicaid waiver described in
8 subsection (a) if the state plan amendment or Medicaid waiver is
9 approved by the United States Department of Health and Human
10 Services and the governor has received the affidavit required
11 under subsection (c).

12 (e) The office may adopt rules under IC 4-22-2 necessary to
13 implement this section.

14 SECTION 10. IC 12-15-46-4 IS ADDED TO THE INDIANA
15 CODE AS A NEW SECTION TO READ AS FOLLOWS
16 [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) Before July 1, 2013, the
17 office shall apply to the United States Department of Health and
18 Human Services for a state plan amendment or a Medicaid waiver
19 requesting to implement a program for individuals who have an
20 annual household income of not more than one hundred
21 thirty-three percent (133%) of the federal income poverty level, as
22 described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

23 (b) The request for a program in the state plan amendment or
24 waiver described in subsection (a) must include the following
25 components:

26 (1) Require a recipient to make out-of-pocket payments
27 related to coverage for health care expenses provided under
28 the program.

29 (2) Require a health care account to be used to pay the
30 recipient's out-of-pocket health care expenses associated with
31 health care coverage provided as part of the recipient's
32 participation in the program described in this section.

33 (3) Include health care initiatives designed to promote the
34 general health and well being of recipients and encourage an
35 understanding of the cost and quality of care.

36 (4) Include coverage for preventative care services provided
37 at no cost to the recipient.

38 (5) Use of a managed care organization model for providing

- 1 **services to program recipients.**
- 2 **(6) Provision of the following services:**
- 3 **(A) Outpatient services.**
- 4 **(B) Inpatient services.**
- 5 **(C) Pharmaceutical services.**
- 6 **(D) Behavioral health.**
- 7 **(E) Other services determined by the office.**
- 8 **(7) Provide incentives for health behavior and encourage an**
- 9 **understanding of the cost and quality of health care.**
- 10 **(8) Require to the fullest extent possible the use of home and**
- 11 **community based services for long term care.**
- 12 **(c) The office may not implement the state plan amendment or**
- 13 **waiver described in this section until the office files an affidavit**
- 14 **with the governor attesting that the state plan amendment or**
- 15 **Medicaid waiver applied for under this section is in effect. The**
- 16 **office shall file the affidavit under this subsection not later than**
- 17 **five (5) days after the office is notified by the United States**
- 18 **Department of Health and Human Services that the state plan**
- 19 **amendment or Medicaid waiver described in this section is**
- 20 **approved.**
- 21 **(d) If the office receives approval for a state plan amendment or**
- 22 **a Medicaid waiver under this section and the governor receives the**
- 23 **affidavit described in subsection (c), the office shall implement the**
- 24 **state plan amendment or Medicaid waiver.**
- 25 **(e) The office may adopt rules under IC 4-22-2 necessary to**
- 26 **implement this section.**
- 27 SECTION 11. IC 12-15-46-4.5 IS ADDED TO THE INDIANA
- 28 CODE AS A NEW SECTION TO READ AS FOLLOWS
- 29 [EFFECTIVE UPON PASSAGE]: **Sec. 4.5. (a) As used in this section,**
- 30 **"Affordable Care Act" refers to the federal Patient Protection and**
- 31 **Affordable Care Act (P.L. 111-148), as amended by the federal**
- 32 **Health Care and Education Reconciliation Act of 2010 (P.L.**
- 33 **111-152).**
- 34 **(b) As used in this section, "exchange" refers to an American**
- 35 **health benefit exchange established for Indiana under the**
- 36 **Affordable Care Act.**
- 37 **(c) The Indiana health benefit exchange advisory committee is**
- 38 **created for the purpose of advising the office with respect to policy**

- 1 **and program administration related to:**
- 2 **(1) an exchange established for Indiana under the Affordable**
- 3 **Care Act consistent with the requirements of federal law; and**
- 4 **(2) implementation of a program under section 4 of this**
- 5 **chapter.**
- 6 **(d) The governor shall appoint nine (9) members of the advisory**
- 7 **committee as follows:**
- 8 **(1) One (1) member who is a representative of health**
- 9 **consumer advocates.**
- 10 **(2) One (1) member who is a representative of small business.**
- 11 **(3) One (1) member who is a self-employed individual.**
- 12 **(4) One (1) member who has expertise in small employer**
- 13 **health insurance coverage.**
- 14 **(5) One (1) member who has expertise in individual health**
- 15 **insurance coverage.**
- 16 **(6) One (1) member who has expertise in administration of a**
- 17 **health benefit plan.**
- 18 **(7) One (1) member who has expertise in administration of a**
- 19 **public or private health care delivery system.**
- 20 **(8) Two (2) members who are eligible for or enrolled in**
- 21 **Medicaid risk-based managed care implemented under**
- 22 **sections 4 and 5 of this chapter.**
- 23 **(e) Three (3) individuals shall serve as ex officio members of the**
- 24 **advisory committee, as follows:**
- 25 **(1) The commissioner or the commissioner's designee, who**
- 26 **shall serve as chairperson.**
- 27 **(2) The secretary of family and social services or the**
- 28 **secretary's designee.**
- 29 **(3) The commissioner of the state department of health, or the**
- 30 **commissioner's designee.**
- 31 **(f) Members of the advisory committee:**
- 32 **(1) shall serve a three (3) year term;**
- 33 **(2) may be reappointed to successive terms; and**
- 34 **(3) serve at the pleasure of the governor.**
- 35 **(g) Members of the advisory committee shall serve without**
- 36 **compensation. However, if sufficient money is available from**
- 37 **federal grant funds or revenues generated by the exchange, each**
- 38 **member may receive the per diem allowance and travel expenses**

1 provided for in rules that apply to executive committees adopted
2 by the Indiana department of administration.

3 (h) The advisory committee shall do the following:

4 (1) Review and comment on policy initiatives related to
5 quality improvement, health care benefits, and eligibility of
6 individuals for coverage through the exchange and
7 implementation of sections 4 and 5 of this chapter.

8 (2) Advise the department in setting budget priorities,
9 including consideration of scope of benefits, beneficiary
10 eligibility, health care professional reimbursement rates,
11 funding outlook, financing options, and possible budget
12 recommendations.

13 (3) Assess the effectiveness of implementation of sections 4
14 and 5 of this chapter.

15 (4) Not later than June 30 of each year, submit
16 recommendations to the governor and, in an electronic format
17 under IC 5-14-6, to the legislative council concerning the
18 implementation of the exchange and of sections 4 and 5 of this
19 chapter.

20 (5) Provide other advisory assistance as requested by the
21 department or other agencies of the state.

22 SECTION 12. IC 12-15-46-5 IS ADDED TO THE INDIANA
23 CODE AS A NEW SECTION TO READ AS FOLLOWS
24 [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) The office shall apply
25 to the United States Department of Health and Human Services for
26 an amendment to the state Medicaid plan to do the following:

27 (1) Require a recipient who has an annual household income
28 of at least one hundred fifty percent (150%) of the federal
29 income poverty level to make premium payments in order to
30 participate in the program.

31 (2) Require Medicaid recipients to participate in cost sharing,
32 as allowable under federal law.

33 (b) The office may not implement the state plan amendment
34 described in this section until the office files an affidavit with the
35 governor attesting that the state plan amendment applied for
36 under this section has been approved by the United States
37 Department of Health and Human Services. The office shall file the
38 affidavit under this subsection not later than five (5) days after the

1 office is notified that the state plan amendment described in this
2 section has been approved.

3 (c) The office may adopt rules under IC 4-22-2 necessary to
4 implement this section.

5 SECTION 13. [EFFECTIVE UPON PASSAGE] (a) As used in this
6 SECTION, "commission" refers to the health finance commission
7 established by IC 2-5-23-3.

8 (b) Before October 1, 2013, the office of Medicaid policy and
9 planning shall present a plan to the commission concerning
10 whether to increase Indiana's use of a risk-based managed care
11 model to provide care to Medicaid populations currently being
12 served under fee-for-service Medicaid. The plan must do the
13 following:

14 (1) Provide an overview of the Medicaid populations in
15 Indiana that are currently being served under fee-for-service
16 Medicaid.

17 (2) Review the use of risk-based managed care for Medicaid
18 populations in other states, including Texas and Florida.

19 (3) Explain any determination that a current fee-for-service
20 Medicaid population should continue to be served under the
21 fee-for-service model.

22 (4) Make recommendations concerning the use of risk-based
23 managed care for Medicaid recipients receiving long term
24 care services.

25 (c) This SECTION expires December 31, 2013.

26 SECTION 14. An emergency is declared for this act.

(Reference is to HB 1591 as introduced.)

and when so amended that said bill do pass.

Representative Clere